OFFICE OF THE GENERAL COUNSEL
Division of Operations-Management

OM MEMORANDUM 87-41 2 July 1987

TO : All Regional Directors, Officers-in-Charge, and Resident Officers

FROM : Joseph E. DeSio, Associate General Counsel

SUBJECT: Proposed New Rules Relating to Collective-Bargaining Units in the Health Care Industry

As you know, the Board has proposed to amend its Rules to include a new provision specifying which bargaining units will be found appropriate in various types of health care facilities. For your information, attached is a copy of the Board's notice of proposed rulemaking and notice of hearing which was published in the Federal Register on 2 July 1987.

Should you have any questions regarding this matter, please contact your Assistant General Counsel.

J. E. D.

Attachment

Federal Register

Thursday
July 2, 1987

Part III

National Labor Relations Board

29 CFR Part 103

Collective-Bargaining Units in the Health Care Industry; Notice of Proposed Rulemaking and Notice of Hearing

S-094999 (020601)(01-JUL-87-15:13:32) F4717.FMT...[36,32]...4-06-87

NATIONAL LABOR RELATIONS BOARD

29 CFR Part 103

Collective-Bargaining Units in the Health Care Industry

AGENCY: National Labor Relations Board.

ACTION: Notice of proposed rulemaking and notice of hearing.

SUMMARY: In order to facilitate the election process, the National Labor Relations Board proposes to amend its rules to include a new provision specifying which bargaining units will be found appropriate in various types of health care facilities. The Board has resolved to utilize notice-and-comment rulemaking rather than be presented with continuing lengthy and costly litigation over the issue of appropriate bargaining units in each case. Interested parties may submit oral testimony in connection with the proposed rules.

DATES: Comments must be received on or before October 30, 1987.

Hearings are scheduled as follows: August 17, 1987, Washington, DC, 9:00 a.m.; August 31, 1987, Chicago, Illinois; September 14, 1987, San Francisco, California.

Persons wishing to present oral testimony at any one of the specified locations shall call or write no later than July 24, 1987.

ADDRESSES: Comments should be sent to: Office of the Executive Secretary, 1717 Pennsylvania Avenue, NW., Room 701, Washington, DC 20570, Telephone: (202) 254–9430.

The hearings will be conducted at the following locations:

(1) *Washington, DC*—The Board's Hearing Room, Sixth Floor, 1717 Pennsylvania Avenue, NW., Washington, DC 20570.

(2) *Chicago, Illinois*—Persons who wish to attend this hearing should contact either the Office of the Executive Secretary or the Board's Chicago Regional Office, Everett McKinley Dirksen Building, 219 S. Dearborn Street, Chicago, Illinois 60604, telephone number (312) 353–7570, to be notified of the exact time and place of the Chicago hearing.

(3) *San Francisco, California*—Persons who wish to attend this hearing should contact either the Office of the Executive Secretary or the Board's San Francisco Regional Office, 901 Market Street, Suite 400, San Francisco, California 94103, telephone number (415) 995–5324, to be notified of the exact time and place of the San Francisco hearing.

Persons wishing to present oral testimony at any one of the specified locations should notify the office of the Executive Secretary, 1717 Pennsylvania Ave., NW., Washington, DC 20570, telephone number (202) 254–9430.

FOR FURTHER INFORMATION CONTACT: John C. Truesdale, Executive Secretary, Telephone: (202) 254–9430.

SUPPLEMENTARY INFORMATION:

I. Background

Since 1974, when Congress extended the protection of the National Labor Relations Act to nonprofit hospitals, the Board has taken literally hundreds of thousands of pages of testimony in a myriad of litigated cases regarding particular circumstances at various health care facilities. Nonetheless, to this day there is no one, generally phrased test for determining appropriate units in this industry that has met with success in the various circuit courts of appeal, and, unfortunately, parties have no clear guidance as to what units the Board and courts will ultimately find appropriate.

At the outset, in a series of 1975 decisions, the Board found appropriate several specific types of units. For example, in *Mercy Hospitals of Sacramento*,[1] after noting the congressional admonition against "undue proliferation," the Board found appropriate a separate unit of registered nurses, finding that they possess "interests evidencing a greater degree of separateness than those possessed by most other professional employees in the health care industry." Thereafter, in *NLRB v. St. Francis Hospital of Lynwood*,[2] the Ninth Circuit rejected the *Mercy* doctrine, finding that the Board had set forth an unwarranted presumption of appropriateness in that adjudicative proceeding,[3] and, further, that the Board had improperly looked for a "community of interests" rather than a "disparity of interests."[4] The Board's later *Newton-Wellesley Hospital* decision[5] represented an explicit effort by the Board to address the Ninth Circuit's concerns in *St. Francis*, but subsequent decisions based on *Newton-Wellesley* met with no greater judicial acceptance.[6] Finally, after a number of years of unsuccessfully advocating variations of the "community of interests" test with respect to registered nurses, the Board, in *North Arundel Hospital Assn.*[7] and *Keokuk Area Hospital*,[8] moved toward the Ninth Circuit's view and held that the disparity of interests test should be applied, having found in *St. Francis Hospital*[9] that that test better met the standards desired by Congress and required by the courts. Yet, recently the D.C. Circuit has severely criticized *St. Francis II*,[10] holding that the disparity test was not mandated by the legislative history, and strongly suggesting that some variation of the historically accepted community of interests standard was required.[11] Similarly, the Second,[12] Eighth,[13] and Eleventh Circuits,[14] while acknowledging the necessity to restrict health care units, have directly or indirectly disagreed with the disparity of interests test.

In cases involving maintenance units, the Board's decisions have, likewise, not achieved judicial acceptance. Nor have Board Members among themselves always agreed on the proper test to apply. In the first lead case, *Shriners Hospitals for Crippled Children*,[15] the Board was split three ways: two members found the requested unit of stationary engineers did not possess a "community of interest sufficiently separate and distinct" to warrant a separate unit; a third member concurred generally; and two other members found the requested unit appropriate. Thereafter, in an attempt to clarify the law in this area, the Board held a special oral argument. Consensus was not achieved. In one case, a majority of the Board found a separate maintenance unit inappropriate;[16] in another, though

[1] 217 NLRB 765, 767 (1975), enf. denied on other grounds 569 F.2d 968 (9th Cir. 1978) cert. denied 440 U.S. 910 (1979).

[2] 601 F.2d 404 (9th Cir. 1979).

[3] Id. at 414–417.

[4] Id. at 418–419.

[5] 250 NLRB 409 (1980).

[6] See, e.g., *NLRB v. HMO International*, 678 F.2d 806 (9th Cir. 1982); *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191 (4th Cir. 1982). See also *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450 (10th Cir. 1981); *Mary Thompson Hospital v. NLRB*, 621 F.2d 856 (7th Cir. 1980).

[7] 279 NLRB No. 48 (Apr. 16, 1986).

[8] 278 NLRB No. 33 (Jan. 27, 1986).

[9] 271 NLRB 946 (1984) (*St. Francis II*).

[10] *Electrical Workers IBEW Local 474 (St. Francis Hospital) v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987).

[11] As concurring Judge Buckley observed, the majority technically left open the possibility the Board was entitled to switch from the community of interests standard, but did so in "ominous tones," thereby rendering an "advisory opinion" on that matter. (Id. at 716).

[12] *Masonic Hall v. NLRB*, 809 F.2d 626 (1987).

[13] *Watonwan Memorial Hospital v. NLRB*, 711 F.2d 848, 850 (1983).

[14] *NLRB v. Walker County Medical Center*, 722 F.2d 1535, 1539 at fn.4 (1984).

[15] 217 NLRB 806 (1975).

[16] *Jewish Hospital of Cincinnati*, 223 NLRB 614 (1976).

finding a unit of stationary engineers to be appropriate, the Board relied on four different rationales.[17] The Board's treatment of this area was criticized by the Third Circuit, which held that in these cases the community of interests standard intended by Congress was a nontraditional one, and that the Board had not struck the proper balance.[18] A similar conclusion was reached by the Seventh Circuit.[19] *In Allegheny General Hospital*,[20] the Board attempted to explain more clearly its rationale in maintenance unit cases, but that effort was not accepted judicially either.[21] Board Members could agree neither on the general test to apply, nor on the correct results in particular cases.[22] A further effort at clarification was made in *St. Francis Hospital*, 265 NLRB 1025 (1982)(*St. Francis I*), which itself contained two separate dissents. Thereafter, the Board issued the aforementioned *St. Francis II* decision, attempting to apply the disparity test so as, it said, better to follow Congress' admonition against undue proliferation. As noted, the D.C. Circuit found that that decision itself represented a misreading of the statute.

Thirteen years and many hundreds of cases later, the Board finds that despite its numerous, well-intentioned efforts to carry out congressional intent through formulation of a general conceptual test, it is now no closer to successfully defining appropriate bargaining units in the health care industry than it was in 1974.

II. Disparity Versus Community Of Interests

In reflecting on the court opinions mentioned above, the Board notes that most courts have tended towards either a "community of interests" or "disparity of interests" test. Though these tests over the past decade or so have developed a "life of their own," and have been taken to refer to more or fewer units, respectively, we believe it appropriate to repeat an earlier Board observation in one lead case, *Newton-Wellesley Hospital*, supra, that various courts' "disagreement with our approach may be largely semantic."[23] As the Board there noted:

> The Board's inquiry into the issue of appropriate units, even in a non-health care industrial setting, never addresses, solely and in isolation, the question whether the employees in the unit sought have interests in common with one another. Numerous groups of employees fairly can be said to possess employment conditions or interests "in common." Our inquiry—though perhaps not articulated in every case—necessarily proceeds to a further determination whether the interests of the group sought are sufficiently distinct from those of other employees to warrant the establishment of a separate unit. We respectfully suggest that, at least to that extent, the test of "disparateness" described by the court is, in practice, already encompassed logically within the community-of-interest test as we historically have applied it, and, accordingly, we interpret the court's direction to the Board to be one of emphasis or degree, and not embracing a distinction of kind.

In one case, after chronicling the checkered and largely unfavorable treatment the Board's broadly stated principles have received from reviewing courts, the Second Circuit concluded that a court sometimes enforces the Board's decision if it "can infer from the Board's result that it has taken the nonproliferation policy into account."[24] The court suggested that perhaps courts "focus * * * on what the Board did as much as on what it said."[25]

The court's analysis of what the Board has done in its hithertofore "doctrinal" approach to health care unit cases was echoed in the description of this process offered by one scholarly commentator:[26]

> Rather than providing a basis for decisions that only a supposedly expert agency could make—by evaluating the available empirical, economic literature an systematically distilling the accumulatd experience of Board personnel and of the labor relations community generally—the Board acts as a kind of Article I "Talmudist" court, parsing precedent, divining the true meaning of some Supreme Court ruling, and balancing in some mysterious fashion competing, yet absolute-sounding values.

The Board has decided that, rather than formulating yet another broadly phrased test for determining appropriate health care units, perhaps a new approach is needed.

III. The Decision To Engage In Rulemaking: Doctrinal Versus Empirical Approach

The focus of all appropriate unit decisions in the health care industry has been the congressional admonition against "undue proliferation." As described in detail above, some Board Members, and some courts, have believed that this permitted a "community of interests" test, with special emphasis on avoiding proliferation. Others have believed this mandated or at least suggested a "disparity of interest" test, with the same emphasis. As noted, the Second Circuit in *Masonic Hall* believed the real test was in the result reached by the Board, i.e., what unit or units were in fact found appropriate. Indeed, at the end of its decision in *Masonic Hall*, the court observed, perhaps wistfully, that "empirical data is not before us."[27]

It is clear to us that the key element in the Board's avoidance of proliferation is to designate how many units will be deemed appropriate in a particular type of health care facility. In so doing, the Board must effectuate section 7 rights by permitting bargaining in cohesive units, units with interests both shared within the group and disparate from those possessed by others; weighed against this must be Congress' expressed desire to avoid proliferation in order to avoid disruption in patient care, unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages, and increased costs due to whipsaw strikes and wage leapfrogging.[28] Though the Board has of times made broad generalizations as to which types of unit configurations would or would not lead to proliferation and the catalogue of undesired results, it cannot be denied that it has never obtained empirical data on these matters. This, along with the still unsettled state of the Board's past doctrinal efforts after so many years, is on major reasons for the Board's deciding to engage in rulemaking.

Another major reason is a reflection of the Board's extensive experience. The Board has in the last 13 years received many hundreds of petitions for health care units. Generally, the units requested have been in approximately six, predictable groupings: registered nurses, other professional employees, technical employees, busines office clerical employees, service and maintenance employees, and skilled

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[17] *St. Vincent's Hospital*, 223 NLRB 636 (1976).

[18] *St. Vincent's Hospital v. NLRB*, 567 F. 2d 588 (3d Cir. 1977).

[19] *NLRB v. West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978).

[20] 239 NLRB 872 (1978).

[21] *Allegheny General Hospital v. NLRB*, 606 F.2d 965 (3d Cir. 1979), denying enf. of 239 NLRB 872.

[22] One court stated the Board's opinions in this area were in a state of "disarray." *Long Island College Hospital v. NLRB*, 566 F.2d 833, 843—844 (2d Cir. 1977), cert. denied 435 U.S. 996 (1978).

[23] 250 NLRB at 411—412.

[24] *Masonic Hall v. NLRB*, 699 F.2d at 637.

[25] Id.

[26] Estreicher, *Policy Oscillation at the Labor Board: A Plea for Rulemaking*, in proceedings of NYU 37th Annual National Conference on Labor (1984), reprinted in 37 Ad. L. Rev. 163, 172 (1985).

[27] 699 F. 2d at 642.

[28] See description of the legislative history contained in *Masonic Hall*, 699 F.2d at 631—632.

maintenance employees.[29] Only occasionally have units of guards or physicians been sought. It is our observation that these groups of employees generally exhibit the same internal characteristics, and relationship to other groups of employees, in one health care facility as do like groups of employees at other facilities. To put the matter another way, the various health care facilities we have examined over the years have looked very much the same as other facilities of the same type: large acute care hospitals, small acute care hospitals, and nursing homes.[30]

To give a more specific example, we have observed that registered nurses perform essentially the same duties at all large acute care hospitals, regardless of which large hospital is involved. Differences are insignificant. For example, despite the emphasis by counsel in the oral argument in the recent *St. Vincent* case (19–RC–11496) on the fact that, in that case, not all RNs were in a single nursing department, we note that the precise same situation prevailed in *Mercy Hospitals of Sacramento*, supra, the first lead case involving registerd nurses after the 1974 amendments.[31] Similarly, it has been our experience that RNs from hospital to hospital receive more or less the same training, uniformly administer drugs and to some extent oversee the work of aides, work at shifts throughout the day and night and on weekends, etc. Despite these similarities, which we are certain are apparent to any labor law practitioner or other knowledgeable person in the health care field, the Board has undertaken to elicit extensive evidence on RNs' duties at each facility sought to be organized, in order to "adjudicate" the appropriate unit in each case. This has come at a tremendous cost to the hospitals, to unions, and to the Board itself, which must furnish hearing officers, court reporters, and lawyers to help the Members decide the cases, based on the heretofore enunciated generalized "doctrines." To the extent one record is different from another, it would appear that is largely the result of counsels' skill or determination in seeking to demonstrate "interchange," "contacts," and the like, mirroring the requirements that have been set forth by the Board in its latest "lead" case. Registered nurses can be expected to communicate with pharmacists about medications, and with maintenance employees about air-conditioning systems, regardless of the facility. Especially in light of the fact that, after 13 years, we are no further along in achieving consensus over doctrine than we were in 1974, and since in any event we are convinced that laborious, costly, case-by-case recordmaking and adjudication in this remarkably uniform field has proved to be an unproductive expenditure of the parties' and the taxpayers' funds, we have decided to engage in rulemaking. The Board is of the opinion that rulemaking, though perhaps time consuming at the outset, will be a valuable long-term investment, paying dividends in the form of predictability, efficiency, and more enlightened determinations as to viable appropriate units, leading ultimately to better judicial and public acceptance.

IV. Power To Engage in Rulemaking

Section 6 of the National Labor Relations Act expressly gives the Board power to make substantive rules:

> The Board shall have authority from time to time to make, amend, and rescind, in the manner prescribed by the Administrative Procedure Act, such rules and regulations as may be necessary to carry out the provisions of this Act.

This is the standard grant of general rulemaking authority given to Federal agencies. The function of such a grant of legislative rulemaking authority is to permit an administrative agency to fill in the interstices of the Act it administers through the quasi-legislative promulgation of rules to be applied in the future, with the choice between proceeding by general rule or by individual, ad hoc litigation "one that lies primarily in the informed discretion of the administrative agency."[32]

Both sections 9(b) and 9(c)(1) on their face appear to give the Board discretion to make unit determinations. It has been argued that the language of section 9(b) requires a separate determination "in each case," and thus that rulemaking as to units is statutorily prohibited. We do not agree. The adaptability of rulemaking proceedings to unit determinations was considered by Kenneth Culp Davis, perhaps the leading authority on administrative law, who concluded:

> The Labor Management Relations Act provides: "The Board shall decide in each case whether . . . the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof . . ." Do the words "in each case" mean that the Board is prohibited from classifying problems, from developing rules or principles, or from relying on precedent cases which establish narrow or broad propositons? The answer has to be clearly no: the Board may decide "in each case" with the help of such classifications, rules, principles, and precedents as it finds useful. The mandate to decide "in each case" does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of deciding "in each case" are classifications, rules, principles, and precedents. Sensible men could not refuse, to use such instruments and a sensible Congress would not expect them to. [Davis, *Administrative Law Text* 145 (3d ed. 1972.)]

The Supreme Court urged the Board to use its rulemaking powers in *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969). As Justice Douglas there stated:

> The rule-making procedure performs important functions. It gives notice to an entire segment of society of those controls or regimentation that are forthcoming. It gives an opportunity for persons affected to be heard. . . . Agencies discover that they are not always repositories of ultimate wisdom: they learn from the suggestions of outsiders and often benefit from that advice. . . . This is a healthy process that helps make a society viable. The multiplication of agencies and their growing power makes them more and more remote from the people affected by what they do and make more likely the arbitrary exercise of their powers. Public airing of problems through rule-making makes the bureaucracy more responsive to public needs and is an important brake on the growth of absolutism in the regime that now governs all of us. . . . Rule making is no cure-all; but but it does force important issues into full public display and in that sense makes for more responsible administrative action. [Id. at 777–779].

Moreover, Congress in 1978 considered, though it failed to pass, legislation that would have required the Board to embrace rulemaking in several areas, including an elaboration of appropriate bargaining units. The Senate committee, in endorsing S. 2467, went so far as to state that "there is no labor relations issue on which there has been such a strong consensus of scholarly opinion as on the proposition that the Board should make greater use of its rulemaking authority under section 6 of the Act." [33]

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[29] See St. Francis I, 265 NLRB at 1029.

[30] Beyond these types of facilities we are not yet able to generalize and so do not now propose to engage in rulemaking.

[31] 217 NLRB at 768. The Board in the early *Mercy* case permitted the 27 RNs working in departments other than nursing to vote under challenge.

[32] *SEC v. Chenery Corp.*, 332 U.S. 194, 203 (1947); *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 294 (1974); *NLRB v. Children's Baptist Home*, 576 F.2d 256, 260 (9th Cir. 1978); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d at 414.

[33] As reported in BNA Special Supplement, DLR, p. 7 (Feb. 6, 1978). Among the many scholars referred to were Peck, *The Atrophied Rule Making Powers of the NLRB*, 70 Yale L.J. 729 (1961); Peck, *A Critique of the National Labor Relations Board's Performance in Policy Formation: Adjudication and*

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Thereafter, the Seventh Circuit, tired of a case-by-case analysis (on a charge nurse-supervisory issue), stated: "while the Board is entitled to some judicial deference in interpreting its organic statute as well as in finding facts, it would be entitled to even more if it had awakened its dormant rulemaking powers for the purpose of particularizing the application * * * to the medical field." *Hillview Health Care Center*, 705 F.2d 1461, 1466 (7th Cir. 1983).

Recent observers of the Board have been similarly supportive.[34] In one recent article, Professor Charles Morris, editor in chief of *The Developing Labor Law*, suggests that "Substantive rulemaking pursuant to the Administrative Procedure Act (APA) and Section 6 of the NLRA is probably the most important thing the Board can do to effectuate its process, economize its time, and advise the people who need to know—most of whom are not lawyers—what the law requires." [35] Morris urges rulemaking with particular reference to collective-bargaining units in the health care industry.[36] As Morris suggests, "The wheel need not be reinvented in every case." [37]

In deciding to engage in rulemaking with respect to appropriate bargaining units in the health care industry, it is the Board's desire to substitute for hithertofore unsuccessful doctrines, and lengthy and costly litigation by the parties to each case who seek primarily to advance their own interests in that case, informed rulemaking. In the course of that process, the Board seeks to obtain that empirical evidence that is one of the chief reasons for engaging in rulemaking,[38] and that was alluded to by the Second Circuit in *Masonic Hall*, 699 F.2d at fn.26.

Depending on the numbers of institutions or persons who desire to give oral testimony, it is the Board's intention to conduct a group of hearings, at which knowledgeable persons can give testimony as to how bargaining in the various units at different types of health care institutions has worked. The Board wants to learn how various bargaining units affect legitimate concerns of both unions and health care employers. For example, when registered nurses have been grouped with other professionals, have their interests been properly represented? Has the bargaining, when it has occurred in all-professional groups, nonetheless proceeded on the basis of each separate profession? Have wage rates been negotiated separately despite the all-professional units? When they have existed, have separate professional groupings resulted in interruption in the delivery of health care? Wage whipsawing? Jurisdictional disputes? These are merely examples of the types of questions that should be addressed by anyone testifying for or against separate units, such as registered nurses, business office clericals, technicals, maintenance employees, etc. The Board is not seeking at the oral hearings the "opinions" and further legal arguments of counsel, which may be submitted as comments, but, rather, actual, empirical, practical evidence offered by industry and union representatives who have themselves participated in or observed bargaining in the health care industry in various configurations. The Board also desires evidence from witnesses with direct knowledge about any recent changes in the delivery of health care, such as cost containment, allegedly greater integration of function between categories of health care employees, and changes in function of specific classifications of health care employees, including greater or lesser degrees of specialization, that may have an impact on the question of appropriate units.

We trust that after receiving and studying such empirical evidence, we will be better able to make an informed judgment as to what units should be found appropriate in the health care industry, because they reflect true community/diversity of interests and do not promote but instead minimize the type of proliferation and interruption of care which concerned Congress in passing the 1974 amendments. No small additional advantage, we hope, will be the attainment of a greater measure of judicial and public deference to what will be our better informed judgment and expertise, with the long-run advantage of settling, finally, the difficult question of appropriate bargaining units in the health care industry.

V. Proposed Rulemaking

The proposed rule which follows is a new endeavor for the National Labor Relations Board, but not for labor-management agencies generally. A number of States have engaged in rulemaking with respect to appropriate bargaining units for their own employees.[39] The proposal that petitions be entertained only in the proposed units is patterned after a similar provision in the Florida and Massachusetts rules. We have decided not to make the units only "presumptively" appropriate, because one important advantage of rulemaking is the certainty it offers; moreover, as previously indicated, our experience has been that facilities and employee functions in hospitals and other health care institutions of approximately the same size and type are virtually identical. Though an "extraordinary circumstances" exception has been included, it is anticipated that the exception will be little used and limited to truly extraordinary situations; the exception is to be construed narrowly and is not intended to provide an opportunity (or loophole) for redundant litigation. The preamble is by its terms limited to petitions for initial organization, since historically the Board has required decertification petitions to be filed in the certified or recognized unit.[40] When institutions are partially organized we assume that petitions for new units will follow the proposed rules, insofar as possible.

There is a provision that the listed units will be the only appropriate units, except that any combination will also be appropriate at the union's option and so long as the requirements of section 9(b)(1) and (3) are met. The union is given the option because the Board will have determined that the dictated number of units do not proliferate, and a petition for one of them will be processed to an election without extensive testimony on that issue; a combination would a fortiori be appropriate, since it would proliferate even less. The reference to section 9(b)(1) is included since the statute requires a self-determination election when professionals are sought to be included with nonprofessionals; a combination of these groups, as with

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Rule Making, 117 U. Pa. L. Rev. 254 (1968); Shapiro, *The Choice of Rulemaking or Adjudication in the Development of Administrative Policy*, 78 Harv. L. Rev. 921 (1965); Bernstein, *The NLRB's Adjudication-Rulemaking Dilemma Under the Administrative Procedure Act*, 79 Yale L.J. 571 (1970); Kahn, *The NLRB and Higher Education: The Failure of Policymaking through Adjudication*, 23 U.C.L.A. L. Rev. 63 at 167–175 (1973); Silverman, *The Case for the National Labor Relations Board's Use of Rulemaking in Asserting Jurisdiction*, 25 Labor L.J. 607 (1974); and Davis, *Administrative Law Treatise* section 6.17 (1970 Supp.).

[34] Estreicher, supra at fn.26; Subrin, *Conserving Energy at the Labor Board: The Case for Making Rules on Collective Bargaining Units*, 32 Lab. L.J. 105 (1981).

[35] Morris, *The NLRB in the Dog House—Can an Old Board Learn New Tricks?*, 24 San Diego L.R. 9 (1987), p. 27.

[36] Id. at 41, fn.149

[37] Id. at 34.

[38] Morris, supra, at 29, 31. See also Subrin, supra at 106–109, 111.

[39] See, e.g., *In the Matter of State of Florida*, 2 FPER 111 (June 17, 1976). Also, amendment to the Rules and Regulations of Massachusetts Labor Relations Commission, adopted 3 March 1977.

[40] *Combell Soup Co.*, 111 NLRB 254 (1955).

RNs (professionals) and LPNs (technicals) at a nursing home, would have to satisfy the 9(c)(1) requirements through the conduct of a *Sonotone*[41] election. Similarly the reference to section 9(b)(3) is included because the statute prohibits the inclusion of guards in bargaining units with other employees.

The proposed rule divides health care facilities into three separate groups. The Board has tentatively decided, based on its experience, that larger hospitals, with their larger numbers of employees in each category, may warrant one or two additional units. In smaller facilities, it is likely that employees will have more contacts with one another, may to some extent perform one another's work, and generally may share interests more than groupings in larger hospitals.[42] A slightly lesser degree of specialization seems also probable. Recognizing that perfection is impossible in this area, but also being intent on not litigating the precise boundaries of the "small hospital" in each case,[43] the Board has tentatively determined that acute care[44] hospitals of more than 100 patient beds will be deemed "large"; acute care hospitals of 100 patient beds or fewer will be deemed "small." The Board will be grateful for interested parties' comments about these definitions during the comment period. No definition of nursing homes seems required. The Board leaves to future proceedings rules with regard to other types of health care facilities.

As for the proposed units, the Board gave considerable thought merely to advising the public that it had decided to engage in rulemaking, leaving wide open the substance of any rule. However, we have decided to offer a proposal with more specifics, solely for purposes of focusing the debate. It is our best judgment that having such a proposal on the floor, for debate, will prove more fruitful than merely inviting open-ended commentary. However, the Board wishes to make it abundantly clear that while the proposed units at this point are based on the Board's cumulative experience and observation, the Board has a completely open mind about which and how many units it will ultimately settle upon. That is the purpose of the comment period and hearings provided for, and the Board will reassess its proposed units before issuing a final rule.

The proposed rule notes that "nothing shall prevent the Board from holding additional hearings concerning the specific job classifications to be included in, or excluded from, each of the above units, and from establishing additional rules, where appropriate, about such matters." That is, after this proceeding, in which the Board will determine the contours of appropriate units, the Board may commence additional rulemaking proceedings to determine the composition of these units, including the professional or technical status of certain classifications which we have encountered frequently in health care cases. As an example, we are advised that there is currently before one regional office a case[45] in which the petition was filed 10 October 1986; hearing commenced 14 November 1986. As of 20 May 1987, the Board had taken testimony covering 24 days of hearing, with more scheduled, covering 5978 transcript pages plus 300 exhibits. At issue is the petitioner's desire for a unit of all service, maintenance, clerical and technical employees with a "community of interest," as opposed to the employer's contention that only an all nonprofessional unit is appropriate. Essentially, the parties differed over the placement of business office clericals, and technicals "without a community of interest," but to some extent 300 classifications were in dispute, some as to whether they were technical or professional, and as to whether they shared interests in common with other, included categories. It has been our observation that classifications in the health care industry are to a large degree standardized, and that future rulemaking to determine what classifications are technical, if that unit is ultimately deemed appropriate, or, alternatively, professional, might further shorten proceedings by eliminating duplicative and in some cases self-evident testimony.

The proposed rule notes that the Board will approve consent agreements providing for elections in accordance with the rule, and that nonconforming agreements will be rejected. Further, the rule will be effective on a prospective basis only, for petitions filed on and after (30 days after publication of the final rule).

VI. Justification For Proposed Units

Initially, we emphasize that, except for information we have gleaned from our decided cases, our proposed rule is not based on empirical evidence concerning health care facilities generally. We anticipate that the testimony and commentary we receive in the course of the rulemaking process will contain a significant amount of the empirical data we need in order to verify or modify our original ideas as to which bargaining units are appropriate.

In formulating our proposed rule, we have, of course, kept firmly in mind Congress's admonition against proliferation of health care bargaining units. However, we also have been mindful of our statutory mandate to make unit determinations "in order to assure to employees the fullest freedom in exercising the rights guaranteed by [the] Act."[46] In addition, we have deemed it significant that the 1974 amendments were intended to encourage collective bargaining by hospital employees in order to improve wages, working conditions, and morale among those employees, reduce turnover, and improve the quality of hospital care.[47] We thus agree with the Second Circuit Court of Appeals that the legislative history of the amendments "does not direct the courts or the Board to erect obstacles to certification of bargaining units that are broader and higher than Congress was itself willing to enact."[48] Consequently, we have drafted the proposed rule with the intent of affording health care employees the "fullest freedom" to organize, while at the same time attempting to avoid the proliferation of bargaining units in that industry that so concerned Congress. We have sought to accomplish this, not by promulgating an abstract standard, but rather by satisfying ourselves that we have limited the possible units in the various types of establishments to a reasonable, finite number of congenial groups displaying both a community of interests within themselves and a disparity of interests from other groups.

The specific units contained in the proposed rule were included, and other possible units were omitted, for the following reasons:

A. Large Acute Care Hospitals

1. *Registered Nurses (RNs).* Because of the numerous differences that commonly exist between RNs and other professional employees, we have tentatively determined that, in large hospitals, separate RN units are appropriate for bargaining. Thus, in comparison with most other professionals, RNs usually work three

[41] *Sonotone Corp.*, 90 NLRB 1236 (1950).

[42] *See, e.g., Mount Airy Psychiatric Center*, 259 NLRB 1003 (1981); see also 217 NLRB 802 (1975).

[43] Subrin, supra, pp. 106–7.

[44] Sec. 2(14) refers to, inter alia, "hospitals" and "convalescent hospitals."

[45] *Christ Hospital*, 9—RC—15019.

[46] Sec. 9(b) of the Act, 29 U.S.C. 159(b).

[47] *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 497–498 (1978); see also *Masonic Hall*, 699 F.2d at 634.

[48] *Id.* at 635.

shifts, round the clock, 7 days a week, have constant responsibility for direct patient care, and are subject to common supervision by other nurses.[48] RNs also share similar education, training, experience, and licensing that are not shared by other hospital employees.[50] Although RNs do have contact with certain other professionals, such as pharmacists, social workers, and physical therapists, such contacts tend to be less frequent than the RNs' contacts with one another.[51] Moreover, RNs have a lengthy history of organization, both professionally and for purposes of collective bargaining.[52] Finally, because our experience has shown that RNs comprise the largest group of professional employees at most health care facilities, granting them (but not other individual professions) their own separate unit will not contribute significantly to proliferation of bargaining units.[53]

2. *Physicians.* For the purposes of the Act, most physicians employed by hospitals are considered either supervisors, managerial employees, or (in the case of interns and residents) students,[54] and hence do not have statutory organizational rights. Accordingly, we envision very few, if any, petitions for separate physicians' units. However, because of physicians' separate education, training, and skills, and particularly because of their unique position as the ultimate supervisors of patient care, we deem it necessary to provide for the possibility of such units in the event they are requested.

3. *Other professional employees.* Section 9(b)(1) of the Act mandates separate representation for professional employees unless a majority of those employees vote for inclusion in a unit with nonprofessionals.[55] The statute thus requires that professional employees not be combined in bargaining units with nonprofessional employees without the consent of the former.[56] While, therefore, a separate unit consisting of all professional employees unquestionably is an appropriate unit for bargaining, for the reasons set forth above, we have (provisionally) determined that separate registered nurses' units also are appropriate. However, in light of the congressional admonition against proliferation of bargaining units, we have determined at this time not to approve separate units of other individual professional employee classifications. Otherwise, we believe, the door would be open to the very fragmentation of bargaining units Congress directed the Board to avoid.

4. *Technical employees.* In our experience, technical employees in hospitals and nursing homes, in comparison with other nonprofessionals, typically have significantly higher levels of skill and training, and are substantially higher paid.[57] Consequently, we have consistently approved separate units of health care technical employees and excluded technicals from units of other nonprofessional employees.[58] Our determinations generally have met with approval from the courts of appeals.[59] Based on our current state of knowledge, we do not discern any reason to depart from our existing practice at this time.

5. *Service, maintenance, and clerical employees (except for Guards).* Service and maintenance employees generally do routine manual work, are not highly skilled or trained, and are paid less than technical employees; consequently, we normally approve separate service and maintenance units.[60] Such determinations have met with court approval.[61] Our proposed rule, however, adds two groups of employees which labor organizations sometimes seek to represent separately, or which labor organizations have sometimes excluded from broader service and maintenance units: clericals and skilled maintenance employees.

We acknowledge that the Board at one time found separate units of business office clerical employees appropriate in health care facilities.[62] More recently, however, our experience has indicated that clericals often share many terms and conditions of employment with service and maintenance employees, and that the two groups have regular, frequent, and significant contacts on the job.[63] Moreover, many employees in health care institutions, besides business office clericals, are engaged in "recordkeeping," such as ward clericals, technicians, nurses, and even physicians. Further, to the best of our knowledge no labor organization has specialized in the representation of business office clericals. For these reasons, and to avoid the proliferation of bargaining units, we have chosen tentatively to include clericals in service and maintenance units. We emphasize, however, that no final decision has been made, and that if evidence exists suggesting that clericals have a distinct community of interests, and that their separate representation would not have unwanted adverse results, such evidence should be presented at the hearings.

Similarly, although at times the Board has in the past approved separate units of skilled maintenance employees (including stationary engineers),[64] in our proposed rule we have provisionally included such employees in service and maintenance units for several reasons. First, we have found that their skill levels at times do not greatly exceed those of other unit employees.[65] Second, many skilled maintenance employees work throughout hospitals' facilities, and thus frequently come into contact with other unit employees.[66] Third, inclusion of skilled maintenance employees in broader units will help to prevent unit proliferation. By contrast, if we were to approve separate skilled maintenance units, many of which would be quite small both in absolute size and relative to the remaining service and maintenance employees, we might well be faced with requests to grant other small units of specialized

[48] See, e.g., *Newton-Wellesley Hospital*, 250 NLRB at 410–411, 413.

[50] Id. at 409, 413.

[51] Id. at 410.

[52] *Mercy Hospitals of Sacramento*, 217 NLRB at 767.

[53] *Newton-Wellesley Hospital*, 250 NLRB at 414–415.

[54] *Cedars-Sinai Medical Center*, 223 NLRB 251 (1976).

[55] 29 U.S.C. 159(b)(1).

[56] *Sonotone Corp.*, supra.

[57] See, e.g., *Southern Maryland Hospital*, 274 NLRB 1470 (1985).

[58] Id. See also *Barnert Memorial Hospital Center*, 217 NLRB 775 (1975); *Newington Children's Hospital*, 217 NLRB 793 (1975).

[59] See, e.g., *Watonwan Memorial Hospital v. NLRB*, 711 F.2d 846 (8th Cir. 1983).

[60] See, e.g., *Newington Children's Hospital*, supra. In that case we observed that "a service and maintenance unit in a service industry is the analogue to the plantwide production and maintenance unit in the industrial sector, and as such is the classic appropriate unit." 217 NLRB at 794.

[61] See, e.g., *Masonic Hall*, supra.

[62] See, e.g., *Sisters of St. Joseph of Peace*, 217 NLRB 797 (1975).

[63] See, e.g., *Baker Hospital*, 279 NLRB No. 36 (Apr. 16, 1986).

[64] See, e.g., *Allegheny General Hospital*, 239 NLRB 672 (1978), enf. denied 608 F.2d 965 (3d Cir. 1979); *Mercy Hospital Assn.*, 236 NLRB 1016 (1978), enf. denied 606 F.2d 22 (2d Cir. 1979), cert. denied 445 U.S. 971 (1980); *Mary Thompson Hospital*, 241 NLRB 766 (1979), enf. denied 621 F.2d/858 (7th Cir. 1980); *West Suburban Hospital*, 227 NLRB 1351 (1977), enf. denied 570 F.2d 213 (7th Cir. 1978); *St. Vincent's Hospital*, 227 NLRB 544 (1976), enf. denied 567 F.2d 586 (3d Cir. 1977). But see *St. Francis II*, supra, and *Shriners Hospital for Crippled Children*, 217 NLRB 806 (1975), denying separate maintenance units.

[65] *St. Francis II*, 271 NLRB at 954.

[66] Id. *Community Hospital of Glen Cove*, 278 NLRB No. 16 (Jan. 17, 1986).

employees: were we to grant such requests, we would open the door to unit fragmentation and proliferation.[67] Finally, as a practical matter, when the Board has approved separate maintenance units, its decisions have fared poorly in the courts.[68]

6. *Guards.* Section 9(b)(3) of the Act requires that guards not be included in a unit with other employees,[69] and therefore separate guard units must be provided for. Our experience indicates, however, that in practice extremely few guard units are petitioned for, perhaps because hospitals often do not employ guards directly, but instead obtain guards from security services.

B. Small Hospitals and Nursing Homes

Our proposed rule contains the same units for small hospitals and nursing homes as for large hospitals, except that instead of providing for separate units of physicians and RNs, it provides for all-professional units. We have tentatively eliminated the narrower units in favor of broader ones because we think that in smaller facilities there will be found less division of labor and specialization, and thus more functional integration of employees' services, than normally is the case in large hospitals. We also expect that there are far fewer professionals other than physicians and nurses in the smaller facilities (especially in nursing homes), and therefore that separate units of "other professionals" are less likely to be appropriate.

VII. Public Hearings

The Board will hold public hearings concerning appropriate bargaining units in the health care industry. The Board wishes to receive testimony and oral presentations from individuals who have direct knowledge of practices in this industry that may have impact on both the number and types of collective-bargaining units that will be permitted. More details about the type of evidence the Board will consider relevant are set forth in section IV above.

The hearings will be conducted at the following locations on the dates indicated:

(1) *Washington, DC*—The hearing will commence at 9 a.m. on August 17, 1987, in the Board's Hearing Room, Sixth Floor, 1717 Pennsylvania Avenue NW., Washington, DC 20570.

(2) *Chicago, Illinois*—The hearing will commence on August 31, 1987. Persons who wish to attend this hearing should contact either the Office of the Executive Secretary (see address section) or the Board's Chicago Regional Office, Everett McKinley Dirksen Building, 219 S. Dearborn Street, Chicago, Illinois 60604, telephone number (312) 353-7570, to be notified of the exact time and place of the Chicago hearing.

(3) *San Francisco, California*—The hearing will commence on September 14, 1987. Persons who wish to attend this hearing should contact either the Office of the Executive Secretary (see address section) or the Board's San Francisco Regional Office, 901 Market Street, Suite 400, San Francisco, California 94103, telephone number (415) 995-5324, to be notified of the exact time and place of the San Francisco hearing.

Persons wishing to present oral testimony at any one of the specified locations should notify the Office of the Executive Secretary, 1717 Pennsylvania Avenue NW., Washington, DC 20570, telephone number (202) 254-9430, no later than July 24, 1987, advising it of the location at which the witness wishes to testify. Thereafter, all witnesses should submit to the Executive Secretary at the above address eight copies of either the written text or a summary of their presentations no later than 1 week prior to the commencement of the hearing at which they wish to testify. Copies of these texts and summaries will be placed in the docket (see sec. VIII, infra) and will be available at the Executive Secretary's Office, and also at the hearing location where the witness intends to testify, for examination by interested persons.

Any member of the public may file a written statement (eight copies) in lieu of oral testimony before, during, or after the hearing, provided that such statement is received by the Board on or before October 30, 1987. Written statements should be addressed to the NLRB's Executive Secretary at the address given in the address section of this preamble, and should refer to Docket No. RM-2.

An administrative law judge will preside over the hearings, which will be informal, legislative-type proceedings at which there are no formal pleadings or adverse parties. In general, oral presentations from individual witnesses will be limited to 20 minutes each, except that the presiding judge may impose a greater or lesser period, at the judge's discretion, if he or she deems it appropriate. Participants may desire to ask questions or crucial issues following a presentation. Such questions may be permitted by the judge, limited to approximately 15 minutes per questioner. Questions must be designed to clarify a presentation and/or elicit information that is within the competence or expertise of the witness; questions that are argumentative or in the nature of a statement will not be permitted. The judge shall have discretion to modify the time for questioning, and shall have further discretion to impose other guidelines for the orderly and effecient conduct of the hearing. This shall include the right to require a single representative to present the views of two or more persons or groups who have the same or similar interests, and to identify such persons or groups with similar interests.

The Board will be represented at the hearings by a member of its staff. The judge and the Board representative shall have the right to question persons making an oral presentation as to their testimony and any other relevant matter.

Comments may be submitted which include data, views, or arguments concerning the proposed rulemaking. These should be submitted (in eight copies) to the Executive Secretary, at the address given in the address section of this preamble, and should refer to Docket No. RM-2. Comments must be submitted by the close of the comment period, which is October 30, 1987.

A verbatim transcript of the hearings, and the written statements and comments, will be available for public inspection during normal working hours at the Office of the Executive Secretary in Washington, DC (see address section of this preamble).

VIII. Docket

The docket is an organized and complete file of all the information submitted to or otherwise considered by the NLRB in the development of this proposed rulemaking. The principal purposes of the docket are: (1) To allow interested parties to identify and locate documents so that they can participate effectively in the rulemaking process and (2) to serve as the record in case of judicial review.

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[67] *Shriners Hospital for Crippled Children*, 217 NLRB at 806. Partly because of the size of the employer groups involved, our tentative decisions to approve separate units for RNs in large acute care hospitals, but not maintenance employee units, are not inconsistent. Maintenance employees usually are few in number, whereas RNs, we have observed, almost always are numerous in absolute terms and typically comprise the majority of professional employees. Maintenance employees are aptly compared to members of other specialized professional or technical groups, such as pharmacists or medical technicians. Although each group is set apart from others to some degree by differing skills, training, etc., under the proposed rule we would not approve separate, specialized units for any such group, but instead would combine them into broader units.

[68] See fn.64, supra.

[69] 29 U.S.C. 159(b)(3).

As required by the Regulatory Flexibility Act, it is hereby certified that this rule will not have a significant impact on small business entities.

List of Subjects in 29 CFR Part 103

Administrative practice and procedure, Labor management relations.

For the reasons set forth in the preamble, it is proposed to amend 29 CFR Part 103 as follows:

PART 103—OTHER RULES

1. The authority citation for 29 CFR Part 103 is revised to read as follows:

Authority: Section 6, National Labor Relations Act, as amended (29 U.S.C. 151, 156), and section 553 of the Administrative Procedure Act (5 U.S.C. 500, 553).

2. Subpart C, consisting of § 103.30, is added to read as follows:

Subpart C—Appropriate Bargaining Units

§ 103.30 Appropriate bargaining units in the health care industry.

(a) With respect to employees of "health care institutions" as defined in section 2(14) of the Act, no petition for initial organization shall be entertained, except under extraordinary circumstances, if the petition seeks certification in a bargaining unit not in substantial accordance with the provisions of this rule. The following shall be the only appropriate units, except that any combination will also be appropriate, as the union's option and so long as the requirements of section 9(b) (1) and (3) are met:

(1) Appropriate units in large, acute care hospitals, which shall be defined as all acute care hospitals having more than 100 patient beds:

(i) all registered nurses.

(ii) All professionals except for registered nurses and physicians.

(iii) All physicians.

(iv) All technical employees.

(v) All service, maintenance and clerical employees except for guards.

(vi) All guards.

(2) Appropriate units in small, acute care hospitals, which shall be defined as all acute care hospitals having 100 patient beds or fewer:

(i) All professional employees.

(ii) All technical employees.

(iii) All service, maintenance and clerical employees except for guards.

(iv) All guards.

(3) Appropriate units in all nursing homes:

(i) All professional employees.

(ii) All technical employees.

(iii) All service, maintenance and clerical employees except for guards.

(iv) All guards.

(4) Appropriate units in all other health care facilities:

The Board for the time being will establish appropriate units in other health care facilities on a case-by-case basis.

(b) Notwithstanding the above, nothing shall prevent the Board from holding additional hearings concerning the specific job classifications to be included in, or excluded from, each of the above units, and from establishing additional rules about such matters. The Board will approve consent agreements providing for elections in accordance with the above rules, and no other agreements will be approved. This rule is to be effective on a prospective basis only, for petitions filed on and after (30 days after publication of the final rule).

Dated, Washington, DC, June 26, 1987.

By direction of the Board.

National Labor Relations Board

John C. Truesdale,

Executive Secretary.

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